

# Disaster Response Medical Information Form

## **Fill out one for each family member; update at least once a year**

\*If you have an unusual chronic illness or allergy, or need special precautions, ask your physician to write out a short explanation and attach to this form.

### GENERAL HEALTH INFORMATION

Name \_\_\_\_\_ gender \_\_\_\_\_ date of birth \_\_\_\_\_

Address \_\_\_\_\_ SS# \_\_\_\_\_

Weight \_\_\_\_\_ hair color \_\_\_\_\_ eye color \_\_\_\_\_ implanted devices \_\_\_\_\_  
(pacemaker, hip joint, etc)

Do you use ☐ glasses ☐ contacts ☐ hearing aid ☐ dentures?

Allergies\* \_\_\_\_\_  
(such as latex, medicines, foods, etc. BE SPECIFIC)

Chronic Illnesses or handicaps\* \_\_\_\_\_  
(transplant recipient, asthma, high blood pressure, diabetes, hearing impaired, etc)

Long Term prescriptions and other medications\* (include dose and frequency) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Family physician/pediatrician \_\_\_\_\_ phone \_\_\_\_\_

### FILL IN DAY FORM IS USED

Current short term illnesses (cold, ear infection) \_\_\_\_\_  
\_\_\_\_\_

Current short term medications (for example: codeine for cough, penicillin) \_\_\_\_\_  
\_\_\_\_\_

### SOURCES OF INFORMATION / HELP

Nearest relative (if child, list custodial parent(s) or guardian)

Name \_\_\_\_\_ phone \_\_\_\_\_

Address \_\_\_\_\_ relationship \_\_\_\_\_

Relative/friend not living in same neighborhood

Name \_\_\_\_\_ phone \_\_\_\_\_

Address \_\_\_\_\_ relationship \_\_\_\_\_

Relative/friend not living in same state—This should be the same for all family members.

Name \_\_\_\_\_ phone \_\_\_\_\_

Address \_\_\_\_\_ relationship \_\_\_\_\_

ADDITIONAL FORMS MAY BE DOWNLOADED AT [www.healthri.org/environment/biot/healthform.pdf](http://www.healthri.org/environment/biot/healthform.pdf)

Or you may make copies of this form on any copy machine.